MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09889

CERTIFICATE OF DEATH

Reg. Dist. No. 16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Rural near Carrollton
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 32 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Rural near Carrollton Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Noah W. Arbaugh

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife: Sarah R. Flater

6(c) If alive, give age: 82 years

7. Birth date of deceased (mo., day, yr.): May 22, 1855

8. AGE: Years	Months	Days	If less than one day
84	4	27	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER 12. Name: Conrad Arbaugh

13. Birthplace: Maryland

MOTHER 14. Maiden name: Ann Maria Evans

15. Birthplace: Maryland

16. Informant: Mrs. Noah W. Arbaugh

Address: Carrollton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 22, 1939 (month) (day) (year)

Cemetery or crematory: Bethel Church of God

Location: near Carrollton

19. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. Oct 21 1939 C R Fogle Dep Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 19, 1939, at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from about Oct. 1st 1933, to Oct. 19th 1939, and that I last saw him alive on Oct. 14th 1939.

Immediate cause of death	DURATION
Coronary Occlusion	
Due to arteriosclerosis	
Due to	
Other conditions Failure Myocardium for some years	

(Include pregnancy within 3 months of death)

Major findings:

20 operations: None

Of autopsy: None

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. O. Billingslea M. D. or other

Address Westminster, Md. Date signed 10/19/39

RECEIVED
NOV 4 1933
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09890

Reg. Dist. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: Taneytown (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 1 yr 6 mos 15 days

Stay in this community (yrs., or mos., or days): —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Frederick

City or town: Frederick Ward No.: (If outside city or town limits, write RURAL NEAR and give town)

Street No.: Odd Fellows Home (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: —

3. (a) FULL NAME: Josephine Atzerodt

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Harry Atzerodt (deceased) 6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Aug 31 st 1854

8. AGE: Years: 85 Months: 1 Days: 18 If less than one day: ____hrs. ____min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual occupation: Practical Nurse

11. Industry or business: —

FATHER — 12. Name: Frank Pitts

13. Birthplace: Washington D.C.

MOTHER — 14. Maiden name: Jane Livingston

15. Birthplace: Washington D C

16. Informant: Evelyn Grace Knowles

Address: 925 Edmonds Ave Drexel Hill Pa

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 20 1939 (month) (day) (year)

Cemetery or crematory: Mt. Olivet

Location: Frederick Md.

18. Funeral director: M. R. Elchesion & Son

Address: Frederick Md.

19. Oct. 19 1939 (Date rec'd by registrar) Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 17th 1939, at 7.15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 2d 1938, to Oct 17 1939, and that I last saw h[er] alive on Oct 17 1939

Immediate cause of death	DURATION
Coronary Thrombosis	Oct 17 39
Due to	
Due to	
Other conditions: Arterio Sclerosis, hypertension	1900

(Include pregnancy within 3 months of death)

Major findings:

Of operations: —

Of autopsy: (not any.)

PHYSICIAN — Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of: —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): —

Means of injury: — Injured at work?

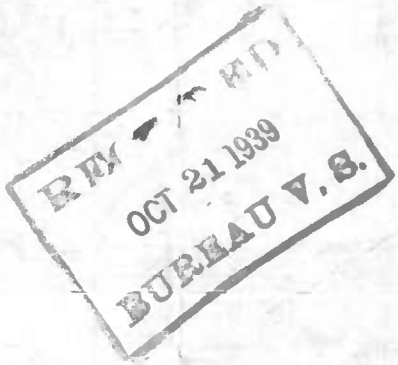
23. SIGNATURE: W. H. Wastin M. D. or other

Address: Taneytown Md. Date signed: Oct 19 39

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15


RECEIVED
OCT 21 1939
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(167)

09891

CERTIFICATE OF DEATH

Reg. Dist. No. 83

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Rural near Gist, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 9 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Rural near Gist Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. R.D. Westminster, Md.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR No

3. (a) FULL NAME John Guy Barker

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1895

8. AGE: Years 44 | Months 5 | Days 2 | If less than one day ____ hrs. ____ min.

9. Birthplace Carroll Co. Maryland
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Farm

FATHER 12. Name John Barker

13. Birthplace Maryland.

MOTHER 14. Maiden name Fannie Williams

15. Birthplace Maryland.

16. Informant Mr. Charles Barker

Address R.D. Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 15, 1939 (month) (day) (year)

Cemetery or crematory Harmony Grove

Location Gist, Carroll Co. Md.

18. Funeral director C.M. Waltz

Address Winfield Md

19. Oct 14 1939 (Date rec'd by registrar) Edna M. Hewitt Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 12 1939, at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____, to ____ 19____, and that I last saw h____ alive on ____ 19____.

Immediate cause of death	DURATION
Gunshot wound of Chest - Probably self inflicted	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 10/12/39

Where did injury occur? Westminster (City or town) Carroll (County) Md (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Gunshot Wound Injured at work?

23. SIGNATURE Jos. T. Marsh Deputy Medical Examiner
M. D. or other

Address New Windsor Md Date signed 10/12/39

RECEIVED
NOV 6 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

09892

(109)

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll County
City or town Baltimore Gamber and Finksburg
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) Life

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Sykesville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Rural - Gist.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Ray Wilson Baugher

3. (b) Social Security Number None

4. Sex Male
5. Color or race White
6. (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 13 - 1938

8. AGE: Years 1 Months 4 Days 22 If less than one day hrs. min.

9. Birthplace Gist (Sykesville - Carroll Md
(Town, county, and state)
10. Usual occupation Infant.
11. Industry or business
FATHER
12. Name Harry C. Baugher
13. Birthplace Lewistown - Fred. Co. Md
MOTHER
14. Maiden name Belva M. Stull
15. Birthplace Lewistown - Fred. Co. Md.
16. Informant Harry C. Baugher
Address Sykesville Md. Route 2
17. Burial Date thereof Oct 7 1939
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Iron Reformed
Location near Lewistown, Fred. Co. Md
18. Funeral director C. M. Waltz
Address Winfield. Md
19. 10/6 1939 L. Woodward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 5 1939, at 7 30 A.M. Prior to

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19 ,
and that I last saw h alive on 19 .

Immediate cause of death Pneumonia - Type unknown, From History. W.G.R.
DURATION 1 da.
Due to no more obtainable.
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy No.

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Jas. T. Marsh Deputy Medical Examiner
M. D. or other
Address Newtown Md Date signed 10/5/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 4 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (97)

Reg. Dist. No. 81

CERTIFICATE OF DEATH

09893

1. PLACE OF DEATH:

(a) County Carroll

(b) City or town Rural - Union Bridge
(If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Maryland (b) County Carroll

(c) City or town Rural - Union Bridge
(If outside city or town limits, write RURAL and give town)

(d) Street No. Linwood Road.
(If rural give location)

(e) If foreign born, how long in U. S. A.? ____ years

3 (a) FULL NAME David Black

3 (b) If veteran, name war

3 (c) Social Security No. NO-NUMBER

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Mary Virginia Hughes

6. (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Sept. 16 - 1866

8. AGE: Years 73 | Months 1 | Days 1 | If less than one day ____ hr. ____ min.

9. Birthplace Uniontown, Carroll Co. Maryland
(Town, county, and state)

10. Usual occupation Laborer.

11. Industry or business Farm.

FATHER
12. Name Benjamin Black
13. Birthplace Carroll Co. Maryland

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known.

16 (a) Informant Mrs Elsie C. Dunson
(b) Address Union Bridge Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 20. 1939 (month) (day) (year)

(c) Cemetery or crematory Mt Joy Cem.
Location Uniontown Md.

18 (a) Funeral director D. D. Hartzler & Sons
(b) Address Union Bridge & New Windsor, Md

19 (a) Oct. 20, 1939 (Date rec'd by registrar) (b) P. Eichman Deputy Registrar

MEDICAL CERTIFICATION

20. Date of death Oct 17 1939, at 1 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10 1939, to Oct 17 1939, and that I last saw him alive on Oct 15 19__.

Immediate cause of death Heart Block — Duration 7 days

Due to Gen'l Arterio Sclerosis — ?

Due to

Other conditions —

(Include pregnancy within 3 months of death)

Major findings: —
Of operations

Of autopsy

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence —

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury —

23. Signature Jas. T. Marsh M. D. ~~Brother~~

Address New Windsor Md Date signed 10/18/39

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 8 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09894

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days): 3 Months 2 Days

Stay in this community (yrs., or mos., or days): (Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Jessups Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Eddie Brinston

3. (b) Social Security Number: ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife: ---

6(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): March 13, 1899

8. AGE: Years	Months	Days	If less than one day
41	6	21	---hrs. ---min.

9. Birthplace: Atlanta, Georgia
(Town, county, and state)

10. Usual occupation: Cook

11. Industry or business: Unknown

FATHER
12. Name: Solmon Brinston
13. Birthplace: Sumpter, South Carolina

MOTHER
14. Maiden name: Pinkey Bradley
15. Birthplace: Sumpter, South Carolina

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-7-39 (month) (day) (year)

Cemetery or crematory: St. Lukes Cem.

Location: Sykesville Md.

18. Funeral director: Bagge & Son Inc.

Address: Sykesville Md.

19. Oct. 5, 1939 (Date rec'd by registrar) Albert R Swanbaum Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 5, 1939 at 4:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 5, 1939 to Oct. 5, 1939, and that I last saw him alive on Oct. 5, 1939.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Aug. 1938
Due to ---	
Due to ---	
Other conditions ---	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: ---

Of autopsy: No Autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide --- Date of --

Where did injury occur? --- (City or town) --- (County) --- (State)

Injured at home, farm, industry, public place (where?) ---

Means of injury -- Injured at work? --

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other

Address: Henryton, Maryland Date signed: 10/5/39

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
NOV 3 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09895

Reg. Dist. No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days): 16 days

Stay in this community (yrs., or mos., or days): (Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 1007 Madison Ave.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Adelaide Florence Carter

3. (b) Social Security Number: ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife: Spencer Carter

6(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Aug. 3, 1914

8. AGE: Years	Months	Days	If less than one day
25	2	5	____ hrs. ____ min.

9. Birthplace: Cooksville, Maryland
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: ---

FATHER
12. Name: Joseph Sands
13. Birthplace: Cooksville, Maryland

MOTHER
14. Maiden name: Florence Smith
15. Birthplace: Cooksville, Md.

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/12/39 (month) (day) (year)

Cemetery or crematory: Arbutus Memorial Ass'n

Location: Balto Md

18. Funeral director: Katie R Williams

Address: 322 N Schroeder St

19. Oct. 8, 1939 (Date rec'd by registrar) Albert R Swanbaum Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 8, 1939 19____, at 1:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 22, 1939 19____ to Oct. 8, 1939 19____, and that I last saw her alive on Oct. 8, 1939 19____.

Immediate cause of death: Pulmonary Tub erculosis — DURATION: June, 1939

Due to: --

Due to: —

Other conditions: --

(Include pregnancy within 3 months of death)

Major findings:

Of operations: --

Of autopsy: No Autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -- Date of: --

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): --

Means of injury: --- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M. D. (M. D. or other)

Address: Henryton, Maryland Date signed: 10/8/39

RECEIVED
NOV 3 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 09896 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 3 Days
Stay in this community (yrs., or mos., or days): (Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Gaithersburg Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME
Frances Alberta Chambers

3. (b) Social Security Number

4. Sex: Female
5. Color or race: Colored
6. (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: ---
6(c) If alive, give age: - years
7. Birth date of deceased (mo., day, yr.): Aug. 27, 1922

8. AGE: Years: 17 Months: 1 Days: 18 If less than one day: hrs. min.

9. Birthplace: Gaithersville, Md. (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: ---

FATHER
12. Name: Alonzo Chambers
13. Birthplace: Gaithersburg, Md.

MOTHER
14. Maiden name: Catherine Frazier
15. Birthplace: Gaithersburg, Md.

16. Informant: Dr. Reuben Hoffman
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 18 1939 (month) (day) (year)
Cemetery or crematory: Brookgrove md
Location: Montgomery Co md
18. Funeral director: Roy W Barber
Address: Laytonsville md

19. 10/16/39 (Date rec'd by registrar) 19 Albert R Swankham Deputy Local Registrar

MEDICAL CERTIFICATION 10:00 A.M.

20. DATE OF DEATH: Oct. 16, 1939 19 , at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 13, 1939 19 , to Oct. 16, 1939, and that I last saw her alive on Oct. 16, 1939 19

Immediate cause of death: Pulmonary Tuberculosis
DURATION: June 1939
Due to: ---
Due to: ---
Other conditions: ---
(Include pregnancy within 3 months of death)
Major findings:
Of operations: ---
Of autopsy: No Autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Maryland Date signed: 10/16/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 3 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

09897

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days): 1 yr. 3 Mo. 6 Da.
Stay in this community (yrs., or mos., or days): (Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 646 W. Lee Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: (John) William Amos Coates

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife: ---

6(c) If alive, give age: -- years

7. Birth date of deceased (mo., day, yr.): Feb. 21, 1918

8. AGE:

Years	Months	Days	If less than one day
21	7	14	---hrs. ---min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: ---

FATHER
12. Name: William Coates
13. Birthplace: Solomon's Island, Md.

MOTHER
14. Maiden name: Ella Foots
15. Birthplace: Solomon's Island, Md.

16. Informant: Dr. Reuben Hoffman,
Address: Henryton, Maryland

17. (Burial, cremation, or removal. Which?) Date thereof: 10/18/39 (month) (day) (year)
Cemetery or crematory: St. Johns. Cal. Co. Md
Location:

18. Funeral director: James A. Hayes
Address: 142 W. Hill St.

19. Oct. 15, 1939 (Date rec'd by registrar) Albert R. Swanblom Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 15, 1939 10:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 9, 1938 to Oct. 15, 1939, and that I last saw h-- im alive on Oct. 15, 1939

Immediate cause of death	DURATION
Pulmonary tuberculosis	Jan. 1938
Due to: --	
Due to: --	
Other conditions: --	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: ---
Of autopsy: No Autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -- Date of:
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ---
Means of injury: --- Injured at work? --

23. SIGNATURE: Reuben Hoffman M.D.
M. D. or other
Address: Henryton, Md. Date signed: 10/15/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 18 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (106-2)

CERTIFICATE OF DEATH

09898

Reg. Dist. No. 78

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Rural near Winfield Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 47 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State Maryland County Carroll
City or town Rural - near Winfield Ward No. Md
(If outside city or town limits, write RURAL NEAR and give town)
Street No. R.D. Mt. Airy. Md
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Naomia Condon

3. (b) Social Security Number No.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ Late Grafton L. Condon
6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) May 8, 1857

8. AGE: Years 82 | Months 5 | Days 9 | If less than one day ____ hrs. ____ min.

9. Birthplace Frederick Co. Maryland.
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER 12. Name George Cookerly
13. Birthplace Maryland.

MOTHER 14. Maiden name Cylinia Bell
15. Birthplace Maryland.

16. Informant Miss Minnie Condon
Address R.D. Mt. Airy Md.

17. Burial Date thereof Oct. 20/1939.
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Ebenezer M.E.
Location Winfield Carroll Co. Md

18. Funeral director E.M. Waltz
Address Winfield. Md

19. 10-18 19 39 E.M. Farver Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17 1939, at 2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 13th 1939, to Oct 17th 1939, and that I last saw h~~e~~r alive on Oct 13th 1939.

Immediate cause of death: Acute Bronchitis — DURATION 6 days
Due to Senility
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE L. E. Stilely M. D. or other
Address New Windsor Md. Date signed 10/18/39

RECEIVED
NOV 6 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(93-d)

09899

CERTIFICATE OF DEATH

Reg. Dist. No. 78

1. PLACE OF DEATH:

County Carroll

City or town Mt Airy - Rural near
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Cover's Corner

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 63 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Mt Mt Airy (Rural) Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. (Cover's Corner)
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME William H. Condon

3. (b) Social Security Number None

4. Sex M

5. Color or race W

6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1876

8. AGE: Years 63 Months – Days – If less than one day hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER
12. Name John Condon
13. Birthplace Md

MOTHER
14. Maiden name ~~Dor~~ Not Known
15. Birthplace "

16. Informant Olin F. Frankling

Address Mt Airy Md

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof Oct. 24 1939
(month) (day) (year)

Cemetery or crematory Taylorsville County

Location Taylorsville Md.

18. Funeral director C. M. Waltz

Address Winfield Md.

19. 10-23- 1939 E. M. Farver
(Date rec'd by registrar) Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Prior to Oct. 22 1939, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19 ,

and that I last saw h alive on 19

Immediate cause of death Probably Broncho-Pneumonia.

Due to Myocarditis and no more obtainable. C.W.G.R.

Due to Arteriosclerosis. Patient was dead before physician saw him.

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy None

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Jas. T. Marsh Deputy Medical Examiner
M. D. or other

Address New Windsor Md Date signed Oct 22/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 6 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09900

Reg. Diat. No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville, Maryland
(If outside city or town limits, write RURAL, NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days) 27 yrs 11 mos 25 da

Stay in this community (yrs., or mos., or days) Life

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Katherine Cooper

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown - 1897 -

8. AGE:

Years	Months	Days	If less than one day
42	-	-	hrs. min.

9. Birthplace: Baltimore County -
(Town, county, and state)

10. Usual occupation: None -

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Maryland

MOTHER
14. Maiden name: Unknown
15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 5th 1939 (month) (day) (year)

Cemetery or crematory: Cathedral Cem.

Location: Baltimore Md.

18. Funeral director: C. H. Weer

Address: Sykesville Md.

19. Oct 2 1939 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2 1939, at 2:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 16 1939, to October 2 1939 -, and that I last saw her alive on October 2 1939 -.

	DURATION
Immediate cause of death: Pulmonary Tuberculosis &	1935
Pleurisy and Effusion	Sept 25-39
Due to	
Due to	
Other conditions: Epilepsy	1910

(Include pregnancy within 3 months of death)

Major findings:

20 operations

20 autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. Virginia Beyer M.D.
M. D. or other

Address Sykesville, Md. Date signed 10-2-39

RECEIVED
OCT 3 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09901

Reg. Dist. No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Sykesville.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Frederick

City or town Frederick Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Unknown
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mae Cramer

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Separated

6 (b) Name of husband or wife (Unknown) Cramer

Unknown 6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27, 1883

8. AGE: Years	Months	Days	If less than one day
59	5	1	hrs. min.

9. Birthplace Frederick City, Maryland
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name James W. Smith

13. Birthplace Frederick Co. - Md.

MOTHER 14. Maiden name Alice Harriet

15. Birthplace Frederick City - Md.

16. Informant Hospital Records.

Address Sykesville Md

17. Burial Date thereof Oct. 30 1939
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Olivet Cem.

Location Frederick, Md.

18. Funeral director Wm. P. Stettinius Hom

Address Frederick Md.

19. Oct. 28 1939 C. Harry Weer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28th 1939, 2.35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 24 1936 to Oct. 28 1939, and that I last saw h alive on Oct. 27 1939.

Immediate cause of death	DURATION
Intestinal Obstruction	
Due to Volvulus and fibrous adhesive band.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy Intestinal obstruction

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Maud M. Rees M.D.
M. D. or other

Address Sykesville, Md Date signed

RECEIVED
NOV 3 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (85)

09902

CERTIFICATE OF DEATH

Reg. Dist. No. 77

1. PLACE OF DEATH:
County Carroll
City or town Near Hampstead Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days) →
Stay in this community (yrs., or mos., or days) 59

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Hampstead, Near Card No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME John Arthur Deal.
3. (b) Social Security Number None

4. Sex Male
5. Color or race White
6. (a) Single, married, widowed, or divorced Married
8 (b) Name of husband or wife Caroline Elizabeth Deal
6(c) If alive, give age 59 years
7. Birth date of deceased (mo., day, yr.) Feb 4 1880.
8. AGE: Years 59. Months 8 Days 17 If less than one day ___ hrs. ___ min.
9. Birthplace Hampstead Md.
(Town, county, and state)
10. Usual occupation Farmer + Hwy dealer
11. Industry or business Farm.
FATHER 12. Name George S Deal
13. Birthplace Maryland
MOTHER 14. Maiden name Charlotte Wheeler.
15. Birthplace Maryland
18. Informant Thelma Deal Kindredmark
Address Hampstead, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 24/39 (month) (day) (year)
Cemetery or crematory St Paul's
Location Arcadia Md
18. Funeral director Edw C Tipton
Address Hampstead Md
19. Oct 23 1939 (Date rec'd by registrar) John S. Hughes Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21 1939, at 2 15 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 8 1935, to Oct. 21 1939, and that I last saw him alive on Oct 21 1939.
Immediate cause of death Acute Cardiac Failure.
Due to Epilepsy
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury injured at work?

23. SIGNATURE Joseph E Bush, M.D.
M. D. or other
Address Hampstead Md Date signed 10-24-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 2 1939
BUREAU V. S.

09903

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94E)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hosp

Stay in hospital or inst. (yrs., or mos., or days): 6 yrs. 5 mo

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Carroll

City or town: — Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: —
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: —

3. (a) FULL NAME: Mollie Delphy

3. (b) Social Security Number:

4. Sex: female

5. Color or race: white

6. (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Alvein Delphy

6 (c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Aug 4th 1867

8. AGE:

Years	Months	Days	If less than one day
72	2	25	hrs. min.

9. Birthplace: Penna.
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business: at home

FATHER
12. Name: Peter Kellerman
13. Birthplace: Penna

MOTHER
14. Maiden name: Mary Johns
15. Birthplace: Penna

16. Informant: James Kellerman

Address: Rocky Ridge Md

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof: Oct. 31 1939
(month) (day) (year)

Cemetery or crematory: Springfield

Location: Sykesville Md.

18. Funeral director: C H Weer

Address: Sykesville Md.

19. Oct 28 1939 C Harry Weer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 27th 1939, at 2:05 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 29th 1939, to Oct 27 1939, and that I last saw her alive on Oct 26 1939.

Immediate cause of death: Bronchopneumonia
Cardiac degeneration

Due to: Coronary arteriosclerosis

Due to:

Other conditions:
(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy: above findings

DURATION: D

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. J. Martin
M. D. or other

Address: Sykesville Date signed: Oct 28/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 3 1939
BUREAU V. S.

09904

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (82-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 82

1. PLACE OF DEATH:

County: Carroll

City or town: Mt. Airy, Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): 45 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Mt. Airy, Md Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: No.

3. (a) FULL NAME: Emily Virginia Etchison

3. (b) Social Security Number: No.

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband ~~or wife~~: late Wm L. Etchison

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): March 9, 1863

8. AGE: Years: 76 Months: 7 Days: 3 If less than one day ____ hrs. ____ min.

9. Birthplace: Frederick Co. Maryland (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER

12. Name: William Duvall

13. Birthplace: Maryland

MOTHER

14. Maiden name: ~~Catherine Malcomb~~ Rachel Condon

15. Birthplace: Maryland

16. Informant: Mrs. Vertie Snyder

Address: Mt. Airy, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 14, 1939 (month) (day) (year)

Cemetery or crematory: Pine Grove

Location: Mt. Airy, Md.

18. Funeral director: C. M. Waltz

Address: Winfield, Md.

18. Oct. 13 1939 (Date rec'd by registrar) Thos D. Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 12, 1939, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1939, to Oct 12 1939 and that I last saw her alive on Oct 12 1939.

Immediate cause of death: Cerebral Hemorrhage — DURATION: 8 hrs

Due to: Arteriosclerosis — yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: C. M. Van Poole M. D. ~~or other~~

Address: Mt. Airy Md Date signed: 10-12-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 6 1939
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

09905

V. S. No. 1

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH (22-a)

County Carroll — Registration Dist. No. 74

Village or City Sykesville, Md. — No. — St., — Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME William R. Fairbank -

(a) Residence: No Sykesville Md., St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~OR DIVORCED~~ (write the word)
Male	White	Married

5e. If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Mary A. Fairbank

6. DATE OF BIRTH (month, day, and year) Oct 27th 1877

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
62	0	4	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Retired Supervisor

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. C & P Tel Co.

10. Date deceased last worked at this occupation (month and year) 1934

11. Total time (years) spent in this occupation 40

12. BIRTHPLACE (city or town) Howard Co. (State or country) Md

FATHER

13. NAME Henry Fairbank

14. BIRTHPLACE (city or town) Md. (State or country)

MOTHER

15. MAIDEN NAME Amanda Miller

16. BIRTHPLACE (city or town) Md (Stete or country)

17. INFORMANT Mary A. Fairbank (Address) Sykesville Md.

18. BURIAL, ~~CREMATION, OR REMOVAL~~ Place Mountain View Howard Co. Md. Date 11/3, 1939

19. UNDERTAKER William Cook (Address) 217 St. Paul St

20. FILED Oct. 31, 1939 C. Harry Keen Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH October (Month) 31 (Day), 1939 (Year)

22. I HEREBY CERTIFY, That I attended deceased from October 6, 1939, to Oct 31, 1939

I last saw h. l. m. alive on Oct 31, 1939; death is said to have occurred on the date stated above, at 5:10 P.m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
Apoplexy	10/6/39
Arterio Sclerosis	
Other Contributory Causes of importance:	
Hypostatic Pneumonia, involving, thereby, terminal pulmonary edema. C.W.S.R.	10/26/39

Name of operation — Date of

What test confirmed diagnosis? — Wes there an autopsy? no

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, sulcide, or homicide? — Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, In HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Wes disease or injury in any wey related to occupation of deceased? no

If so, specify

(Signed) W. H. Lawson M. D.

(Address) Sykesville Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

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Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09906

Reg. Dist. No. 70

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Taneytown
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Carroll

City or town Taneytown Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME

Mrs. Leah Alverta Garner

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6 (b) Name of husband ~~or wife~~ D. W. Garner

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 7, 1861

8. AGE: Years	Months	Days	If less than one day
78	1	7	hrs. min.

9. Birthplace Adams Co., Pa.
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER 12. Name Amos Basehoar

13. Birthplace Pa

MOTHER 14. Maiden name Catherine Sheely

15. Birthplace Pa

16. Informant Mrs. John M. Hoagland

Address Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 21 1939 (month) (day) (year)

Cemetery or crematory Lutheran

Location Taneytown, Md.

18. Funeral director C. O. FUSS & SON

Address Taneytown, Md.

19. Oct 21 1939 Ethel M Mehring
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18th 1939, at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 14th 1939 to Oct 18th 1939 and that I last saw h er alive on Oct 18th 1939.

Immediate cause of death Cerebral Hemorrhage — DURATION 4 days

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. M. Benner M.D. M. D. or other

Address Taneytown Md Date signed Oct 20th 1939.

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 25

09907

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Henryton
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days) 14 Days

Stay in this community (yrs., or mos., or days) (Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 503 W. Hoffman St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Lucinda Jane George

3. (b) Social Security Number ---

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife Livy George

6(c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.) March 12, 1917

8. AGE:

Years	Months	Days	If less than one day
22	7	8	___ hrs. ___ min.

9. Birthplace Chester, S. C.
(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business ---

FATHER
12. Name Lewis Pohe
13. Birthplace Chester, S. C.

MOTHER
14. Maiden name Phyllis Drummer
15. Birthplace Blackstone, S. C.

16. Informant Dr. Reuben Hoffman
Address Henryton, Maryland

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof Oct 25 1939 (month) (day) (year)

Cemetery or crematory

Location Chester, S. C.

18. Funeral director Adolphus Haltrad
Address 918 Dund Hill Ave

19. 10/20/39 19 Albert R Swankhaus
(Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 20, 1939 9:15 P.M. 19 , at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 6, 1939 19 , to Oct. 20, 1939 19 , and that I last saw her alive on Oct. 20, 1939 19

Immediate cause of death Tuberculous Peritonitis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy No Autopsy

DURATION Feb. 2, 1939

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide -- Date of --

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ---

Means of injury --- Injured at work? --

23. SIGNATURE Reuben Hoffman, M.D.
M. D. or other

Address Henryton, Maryland Date signed 10/20/39

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09908

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days): 2 months 5 days

Stay in this community (yrs., or mos., or days): (Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Salisbury Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: no

3. (a) FULL NAME: Lillian Hester Gilreath

3. (b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife: Eli Gilreath

6(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): May 6, 1887

8. AGE: Years	Months	Days	If less than one day
52	5	7	____ hrs. ____ min.

9. Birthplace: Salisbury, Wicomico County, Md.
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: ---

FATHER 12. Name: Thomas Furr

13. Birthplace: Quanitco, Maryland

MOTHER 14. Maiden name: Henrietta Robinson

15. Birthplace: Quantico, Maryland

16. Informant: Dr. Reuben Hoffman

Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct/15, 1939 (month) (day) (year)

Cemetery or crematory: Hanston

Location: Salisbury md

18. Funeral director: James F. Stewart

Address: Salisbury md

19. 10/13/39 (Date rec'd by registrar) 19 Albert R Swankhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 13, 1939 19____, at 5:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 28, 1939 19____, to Oct. 13, 1939 19____, and that I last saw her alive on Oct. 13, 1939 19____.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec. 1938
Due to --	
Due to --	
Other conditions --	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: ---

Of autopsy: No Autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -- Date of: --

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): --

Means of injury: --- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M. D. M. D. or other

Address: Henryton, Maryland Date signed: 10/13/3

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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OCT 20 1939
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MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09909

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Westminster
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Charles St.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 10 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Carroll
City or town Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Charles St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR ✓

3. (a) FULL NAME Singelton Barnes Hammond

3. (b) Social Security Number

4. Sex Male
5. Color or race Colored ✓
6. (a) Single, married, widowed, or divorced single
6 (b) Name of husband or wife ✓
6(c) If alive, give age ✓ years
7. Birth date of deceased (mo., day, yr.) Oct. 13, 1861

8. AGE: Years 78 Months 9 Days 18 If less than one day ___ hrs. ___ min.

9. Birthplace Defiance Carroll Co. Md.
(Town, county, and state)
10. Usual occupation Waiter & porter
11. Industry or business

FATHER
12. Name ✓
13. Birthplace Carroll Co.

MOTHER
14. Maiden name ✓
15. Birthplace Carroll Co.

16. Informant Mrs. Esther K. Brown
Address Carroll Co. Welfare Workers
17. Burial Westminster, Md.
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year) 10 3 39
Cemetery or crematory Fairview
Location Covers Corner, Carroll Co. Md.
18. Funeral director J. E. Myers Jr.
Address Westminster Md.
19. 10/2 1939 T. K. Woodward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1 1939, at 4.30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 22 1939, to Oct 1. 1939, and that I last saw him alive on Sept 30 1939.

	DURATION
Immediate cause of death Acute cardiac dilatation.	1 day
Due to chronic myocarditis	1 year
Due to arteriosclerosis	10 years
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Chas R Foutz MD
M. D. or other
Address Westminster Md. Date signed Oct. 2. 39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09910

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 2 yrs 7 mos 15 days

Stay in this community (yrs., or mos., or days): —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Washington

City or town: Sharpsburg Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: —

3. (a) FULL NAME: Annie S Hines

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6 (b) Name of husband or wife: —

6(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): 1870

8. AGE:

Years	Months	Days	If less than one day
69	—	—	____hrs. ____min.

9. Birthplace: Sharpsburg Md.
(Town, county, and state)

10. Usual occupation: Teacher

11. Industry or business: Public School

FATHER
12. Name: Samuel Hines
13. Birthplace: Sharpsburg Md.

MOTHER
14. Maiden name: Mary Zimmerman
15. Birthplace: Sharpsburg Md

16. Informant: William Hines
Address: 4426 Grant Rd N W Wash D C

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 17 1939 (month) (day) (year)

Cemetery or crematory: Mountain View

Location: Sharpsburg

18. Funeral director: Edith V. Keefer

Address: Williamsport Md.

19. Oct 16 1939 (Date rec'd by registrar) Mary Keen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 15th 1939, at 7-15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 2 1937, to Oct 15 1939, and that I last saw her alive on Oct 14 1939

	DURATION
Immediate cause of death: Coronary arteriosclerosis and occlusion prior to	10/15/39
Due to: Generalized arteriosclerosis and chronic myocarditis prior to	3/2/37
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy: General, cerebral & coronary arteriosclerosis

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. G. Wastler M. D.

Address: Sykesville Md. Date signed 10-15-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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NOV 3 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09911

Reg. Dist. No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Sykesville

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days) 5 years 2 mo.

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Baltimore Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 808 E. St. Paul St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Lula Hofmeister

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	married

6 (b) Name of husband or wife Julius K. Hofmeister

6(c) If alive, give age Living years

7. Birth date of deceased (mo., day, yr.) August 17, 1856.

8. AGE: Years 53 | Months 1 | Days 27 | If less than one day ____ hrs. ____ min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Jonathan K. Crewe

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden name Elizabeth K. Copper

MOTHER 15. Birthplace Maryland

16. Informant Husband

Address 808 E. St. Paul St. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 15-39. (month) (day) (year)

Cemetery or crematory Cemetery, Oak Lawn

Location Balto. Md.

18. Funeral director Wm. M. Magrath

Address 715 E. Lafayette St.

19. Oct. 13 1939 (Date rec'd by registrar) Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 13th. 1939, at 6.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 7 1939, to Oct. 13th. 1939, and that I last saw h alive on Oct. 12th. 1939.

Immediate cause of death	DURATION
Lobar Pneumonia	6 days
Due to	
Due to	
Other conditions Salicylism.	1934

(Include pregnancy within 3 months of death)

Major findings:

Of operations /

Of autopsy /

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Maud M. Rees M.D. M. D. or other

Address Sykesville, Md. Date signed 10-13-39

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BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore 47-B

09912

CERTIFICATE OF DEATH

Reg. Dist. No. 77

1. PLACE OF DEATH:
County: Carroll
City or town: Hampstead Md - Rural Near
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: —
Stay in hospital or inst. (yrs., or mos., or days): —
Stay in this community (yrs., or mos., or days): 21 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Hampstead Md - Rural Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. —
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME: Jessie L. Hooper

3. (b) Social Security Number:

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband~~ or wife: Virginia Hooper
6 (c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): May 21 - 1867

8. AGE: Years 72. Months 4 Days 23 If less than one day ___ hrs. ___ min.

9. Birthplace: Maryland (Town, connty, and state)
10. Usual occupation: Farmer.
11. Industry or business: own farm

FATHER
12. Name: William Hooper
13. Birthplace: Maryland

MOTHER
14. Maiden name: Elizabeth Sharretts
15. Cirthplace: Penna.

16. Informant: Mrs Jesse L Hooper
Address: Hampstead Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 16 - 1939 (month) (day) (year)
Cemetery or crematory: Stone Chapel
Location: Rikesville Md

18. Funeral director: Edw C Tipton
Address: Hampstead Md

19. Oct 14 1939 (Date rec'd by registrar) John S. Hughes Jr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 14 1939, at 3 45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 17 1939, to Oct 14 1939, and that I last saw him alive on Oct 14 1939.

Immediate cause of death: Carcinoma of Lung. c̄ Hemathorax
DURATION: ?
Due to
Due to
Other conditions: Chronic Cardio-Vascular Disease - ?
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy: None.

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury Injured at work?

23. SIGNATURE: Joseph E. Bush M.D. M. D. or other
Address: Hampstead Md Date signed: 10-14-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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NOV 2 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23

09913

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville, Md.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days) 14 yrs. 11 mos. 4 days

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 517 E. Clement Street

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME George Hutton

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years 61 | Months | Days | If less than one day ____hrs. ____min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name James Hutton

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden name Mary Ramegar

MOTHER 15. Birthplace Maryland

16. Informant Hospital Records

Address Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 20 1939 (month) (day) (year)

Cemetery or crematory Linden Park

Location Frederick Rd.

18. Funeral director Margaret G. Flynn

Address 1432 Light St.

19. Oct. 17 1939 (Date rec'd by registrar) Mary Hess Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17 1939, at 11:25 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 8 1939 to October 17 1939, and that I last saw him alive on October 17 1939

Immediate cause of death Pulmonary Tuberculosis — OURATION Known Oct. 5-'39

Due to

Due to

Other conditions Epilepsy — 50 yrs.

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. Virginia Beyer M.D. M. D. or other

Address Sykesville, Md. Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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09914

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (82-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Finksburg Carroll Co.

City or town _____ (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: _____

Stay in hospital or inst. (yrs., or mos., or days) _____

Stay in this community (yrs., or mos., or days) 50 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County Carroll

City or town Finksburg Ward No. _____ (If outside city or town limits, write RURAL NEAR and give town)

Street No. _____ (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR _____

3. (a) FULL NAME Thomas M. Ireland

3. (b) Social Security Number _____

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Fannie H. Ireland

6(c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) October 8, 1858

8. AGE: Years	Months	Days	If less than one day
81		9	____ hrs. ____ min.

9. Birthplace Carroll Co. (Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business

FATHER 12. Name Edward Ireland

13. Birthplace Carroll Co.

MOTHER 14. Maiden name Elizabeth Calhoon

15. Birthplace Penna.

16. Informant Frank H. Ireland

Address 2642 Guilford Ave. Balto. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 19, 1939 (month) (day) (year)

Cemetery or crematory Finksburg Cem.

Location Carroll Co.

18. Funeral director J. F. Eline & Sons

Address Reisterstown, Md.

19. Oct. 18 1939 (Date rec'd by registrar) C. R. Fogle Lec Dep Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17th 1939, 12 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 13th 1939, to Oct 17th 1939, and that I last saw him alive on Oct 17th 1939.

Immediate cause of death Cerebral Hemorrhage

Due to Arterial Sclerosis

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy No

DURATION 4 dy Seved yr

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE J. Frank Miller M.D. M. D. or other

Address Reisterstown Md Date signed 10/17/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09915

Reg. Dist. No. 82

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Rural nr. Mt. Airy
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 45 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland. County Carroll.
City or town Rural nr Mt. Airy (Ward No.) Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. R. D. # 4
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mary E. Jones.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married.

6 (b) Name of husband ~~or wife~~ Robert E. Jones
6(c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) April 5, 1866

8. AGE:

Years	Months	Days	If less than one day
73	6	5	____ hrs. ____ min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Rachel Dorsey.
13. Birthplace Md.
MOTHER 14. Maiden name Caroline Ryan
15. Birthplace Md.
16. Informant Robt. E. Jones.
Address R.D. Mt. Airy. Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 12, 1939 (month) (day) (year)
Cemetery or crematory Mt. Zion
Location near Mt. Airy, Md.
18. Funeral director Chas. Waltz
Address Woodbine Md.
19. Oct. 12 1939 (Date rec'd by registrar) Thos. D. Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 10 1939 at 1:55 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 7, 1939 to Oct 10 1939, and that I last saw h-- alive on Oct 10 1939.

	DURATION
Immediate cause of death Cardiac Decompensation	2 wks
Due to Chr. Myocarditis	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. Stanley Gambill M. D. or other
Address Mt. Airy Md. Date signed 10/11/39

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09916

Reg. Dist. No. 77

1. PLACE OF DEATH:
County Carroll
City or town Near Hampstead
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:

Stay in hospital or Inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 57 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Near Hampstead Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Katie B Lebrun

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Fuller Lebrun
6(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) March 7 - 1882

8. AGE: Years 57 | Months 8 | Days 9 | If less than one day ____ hrs. ____ min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

FATHER 12. Name unknown

13. Birthplace "

MOTHER 14. Maiden name Annie C Harris

15. Birthplace Maryland

16. Informant Fuller Lebrun

Address Hampstead Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 18/39 (month) (day) (year)

Cemetery or crematory Shiloh

Location Carroll County Md

18. Funeral director Edw C Tipton

Address Hampstead Md

19. Oct 16 1939 (Date rec'd by registrar) John S. Hughes Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October, 16 1939 at 7:30a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1938, to Oct. 16 1939, and that I last saw he alive on Oct. 12 1939.

Immediate cause of death	DURATION
Carcinoma of Liver (Primary)	8 mo
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy Carcinoma of Liver

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Maurice C. Porter, M.D. or other
Address Hampstead, Md Date signed 10/18/39

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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STATE OF MARYLAND—CERTIFICATE OF DEATH

09917

1. PLACE OF DEATH (82-01)

County Carroll Registration Dist. No. 81

Village or City Union Bridge No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Mary Carrie Mackley

(a) Residence: No. Union Bridge St., Ward Maryland

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Mackley

6. DATE OF BIRTH (month, day, and year) June 23 1872

7. AGE Years 67 Months 4 Days If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Home

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Own Home

10. Date deceased last worked at this occupation (month and year) 1930

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Maryland

FATHER

13. NAME Joseph H. Creager

14. BIRTHPLACE (city or town) (State or country) Maryland

MOTHER

15. MAIDEN NAME Susan C. Musselman

16. BIRTHPLACE (city or town) (State or country) Pa.

17. INFORMANT (Address) Charles Mackley Union Bridge

18. BURIAL, CREMATION, OR REMOVAL Place Union Bridge Date Oct 25, 1939

19. UNDERTAKER (Address) Raymond K Wright Union Bridge Md

20. FILED Oct. 25, 1939 P. Eichman Deputy Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH October (Month) 22 (Day), 1939 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Oct 1, 1939, to Oct 22, 1939

I last saw her alive on Oct 22, 1939; death is said to have occurred on the date stated above, at 6 P m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows: Cerebral Hemorrhage. Date of onset

Other Contributory Causes of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) J. H. Missley M. D.

(Address) Johnsville, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

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Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

09918

Reg. Dist. No. 76

1. PLACE OF DEATH:
County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 130 East Main Street
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 1521 North Broadway
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Frank B. Matthews

3. (b) Social Security Number:

4. Sex: male
5. Color or race: white
6. (a) Single, married, widowed, or divorced: widowed
6 (b) Name of husband or wife: Lillian M. Townsend
6(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): November 29, 1868
8. AGE: Years: 70 Months: 10 Days: 6 If less than one day: hrs. min.
9. Birthplace: Westminster, Carroll, Md.
(Town, county, and state)
10. Usual occupation: Officer
11. Industry or business: Maryland Penitentiary
FATHER
12. Name: Robert Charles Matthews
13. Birthplace: Maryland
MOTHER
14. Maiden name: Harriet Culnan
15. Birthplace: Maryland
16. Informant: Miss Louise Matthews
Address: Westminster, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 7, 1939 (month) (day) (year)
Cemetery or crematory: Westminster
Location: Westminster, Md.
18. Funeral director: J. Francis Reese
Address: Westminster, Md.
19. 10/6 1939 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 5, 1939, at 11 a M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 0 19 , to 0 19 ,
and that I last saw him alive on Oct 4 - 1939.
Immediate cause of death: Acute Dilatation of Heart. DURATION: a few minutes
Due to:
Due to:
Other conditions: Arteriosclerosis
(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Chas. R. Fouty M.D. M.D. or other
Address: Westminster Date signed: 10-6-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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09919

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8200)

CERTIFICATE OF DEATH

Reg. Dist. No. 72.

1. PLACE OF DEATH:

County Carroll

City or town Westminster, Md - R.D. 2.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 20 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State County

City or town Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Frank Peter McAllister

3. (b) Social Security Number

4. Sex Male

5. Color or race Nufrite

6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Rose (Brown) McAllister

6(c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) Feb. 16 - 1870

8. AGE: Years 69 Months 8 Days 11 If less than one day hrs. min.

9. Birthplace Perry Co. Penna.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Farm

FATHER
12. Name David McAllister
13. Birthplace Pennsylvania

MOTHER
14. Maiden name Maria Smith
15. Birthplace Pennsylvania

16. Informant Hazel M. Deetherer

Address Oella Md.

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof Oct-30-1939
(month) (day) (year)

Cemetery or crematory Deer Park Cem.

Location Balto Co. near Reisterstown Md.

18. Funeral director J. W. Little & Son

Address Littlestown, PA. Pr R.A.S.

19. Oct. 28th. 1939. Calvin E. Bankert,
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 27th 1939, at 1:11 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 15 1939, to Oct 26 1939, and that I last saw him alive on Oct 26 1939.

Immediate cause of death Cerebral Hemorrhage

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John J. Stewart M. D. or other 1939

Address Westminster Md Date signed Oct 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09920

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 5 yrs 2 mos

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Lonaconing Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: -

3. (a) FULL NAME: Josephine Metz

3. (b) Social Security Number:

4. Sex: female | 5. Color or race: white | 6. (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Lenard Metz

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 26 - 1884

8. AGE: Years: 54 | Months: 3 | Days: 12 | If less than one day: hrs. min.

9. Birthplace: Westernport Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: at home

FATHER — 12. Name: John J Higgins

FATHER — 13. Birthplace: Ireland

MOTHER — 14. Maiden name: Catherine Horan

MOTHER — 15. Birthplace: Piedmont W Va

16. Informant: Lenard Metz

Address: Lonaconing Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 30 1939 (month) (day) (year)

Cemetery or crematory: Cemetery "Oak Hill"

Location: Lonaconing Md

18. Funeral director: M. Eichhorn

Address: Lonaconing Md

19. Oct. 28 1939 (Date rec'd by registrar) C Nancy Steer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 27 1939, at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 30 1934, to Oct 27 1939, and that I last saw h[illegible] alive on Oct 27 1939

Immediate cause of death	DURATION
~~General arter~~ Cerebral infarction	7
Due to Cerebral arteriosclerosis	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy: Cerebral infarction + Gen. arteriosclerosis

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J J Gaston M. D. or other

Address: Sykesville Md Date signed: 10-28-39

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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STATE OF MARYLAND—CERTIFICATE OF DEATH

09921

V. S. No. 1

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH (82-0)

County Carroll Registration Dist. No. 70

Village or City Taneytown R.D. No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Mrs. Sarah C. Munshower

(a) Residence: No. St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F	W	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Munshower

6. DATE OF BIRTH (month, day, and year) Dec. 21, 1892

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	8	26	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Housewife

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Md (State or country)

FATHER

13. NAME Henry Eicholtz

14. BIRTHPLACE (city or town) Md (State or country)

MOTHER

15. MAIDEN NAME Adelina---Unknown**

16. BIRTHPLACE (city or town) Md. (State or country)

17. INFORMANT Harry Munshower (Address) Taneytown, Md.

18. BURIAL, CREMATION, OR REMOVAL

Lutheran Taneytown Date Oct. 20, 1939.

19. UNDERTAKER C. O. FUSS & SON (Address) Taneytown, Md.

20. FILED Oct. 19, 1939 Ethel M Metzing Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Oct (Month) 17th (Day), 1939 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Oct 16th, 1939, to Oct 17th, 1939

I last saw h-e alive on Oct 17th, 1939; death is said to have occurred on the date stated above, at 11:30 A. m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage	Oct 16 1939

Other Contributory Causes of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) C. M. Benner M. D.

(Address) Taneytown Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

NOV 3 1939 BUREAU V. S.

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09922

Reg. Dist. No. 77

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Greenmount Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 65 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Greenmount Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Conrad H. Nagle

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

B (b) Name of husband or wife: Mary E Nagle

6(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): April 2nd 1874

8. AGE:

Years	Months	Days	If less than one day
65	6	19	____ hrs. ____ min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER 12. Name: Conrad H Nagle

FATHER 13. Birthplace: Germany

MOTHER 14. Maiden name: Sarah Brilhart

MOTHER 15. Birthplace: Maryland

16. Informant: Mary E Nagle

Address: Greenmount Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-24-39 (month) (day) (year)

Cemetery or crematory: Greenmount

Location: Carroll Co. Md.

18. Funeral director: Jacob Wink's Sons

Address: Manchester Md

19. Oct 22 1939 (Date rec'd by registrar) John S. Hughes Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 21 1939, at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1939, to Oct 21 1939, and that I last saw him alive on Oct 21 1939.

Immediate cause of death: Carcinoma of Stomach — DURATION: 1 year

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: William R S Denner M. D. or other

Address: Manchester Md Date signed 10/22/39

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NOV 2 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

09923

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton,
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch
Stay in hospital or inst. (yrs., or mos., or days) 4 Mo. 13 days
Stay in this community (yrs., or mos., or days) (Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 148 Dolphin Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Lorraine Patterson

3. (b) Social Security Number

4. Sex: Female
5. Color or race: Colored
6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife ---
6(c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.) Aug. 29, 1933

8. AGE: Years 6 | Months 1 | Days 16 | If less than one day ___ hrs. ___ min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation None

11. Industry or business ---

FATHER
12. Name William Patterson
13. Birthplace Richmond, Virginia

MOTHER
14. Maiden name Bertha Wilson
15. Birthplace South Carolina

16. Informant Dr. Reuben Hoffman
Address Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year) Oct 18 1939
Cemetery or crematory
Location Mt Albion County

18. Funeral director Adolphus Halstead
Address 918 Druid Hill Ave.

19. 10/15/39 (Date rec'd by registrar) 19 Albert R Swankhouse Deputy Local Registrar

MEDICAL CERTIFICATION 10:45 P.M.

20. DATE OF DEATH Oct. 15, 1939 19 , at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 2, 1939 19 , to Oct. 15, 1939 19 ,
and that I last saw her alive on Oct. 15, 1939 19 .

Immediate cause of death: Pulmonary Tuberculosis — DURATION: April 1939
Due to --
Due to ---
Other conditions ---
(Include pregnancy within 3 months of death)
Major findings:
Of operations ---
Of autopsy No Autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide -- Date of --
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) --
Means of injury -- Injured at work? --

23. SIGNATURE Reuben Hoffman, M.D. M. D. or other
Address Henryton, Maryland Date signed 10/15/3

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09924

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days): 3 months 1 day

Stay in this community (yrs., or mos., or days): (Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Pr. George's

City or town: Westwood Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Mamie Florence Pinkney

3. (b) Social Security Number: ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6 (b) Name of husband or wife: ---

6(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): Jan. 21, 1917

8. AGE:

Years	Months	Days	If less than one day
22	8	15	---hrs. ---min.

9. Birthplace: Westwood, Maryland
(Town, county, and state)

10. Usual occupation: Cook

11. Industry or business: ---

FATHER
12. Name: Thomas Pinkney
13. Birthplace: Unknown

MOTHER
14. Maiden name: Maddie Skiner
15. Birthplace: Unknown

16. Informant: Dr. Reuben Hoffman

Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 9 1939 (month) (day) (year)

Cemetery or crematory: St. Thomas Church Cem.

Location: Aquasco, Md.

18. Funeral director: Andrew J. Timms

Address: Aquasco, Md.

19. Oct. 6, 19 39 (Date rec'd by registrar) Albert R Swankhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 6, 1939 19---, at 3:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 5, 1939 19--- to Oct. 6, 1939 19---, and that I last saw h-- or alive on July 6, 1939 19---

Immediate cause of death	DURATION
Pulmonary Tuberculosis	June 1939
Due to --	
Due to --	
Other conditions --	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: ---

Of autopsy: No Autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of: --

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): --

Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M.D.
M. D. or other

Address: Henryton, Maryland Date signed: 10/6/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-C)

CERTIFICATE OF DEATH

09925

Reg. Dist. No. 71

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Union Bridge, Md. Near Uniontown
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State County

City or town Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Sarah Elizebeth Repp

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Monnaso O. Repp

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 18th 1848

8. AGE: Years	Months	Days	If less than one day
91	8	15	hrs. min.

9. Birthplace Frederick County
(Town, county, and state)

10. Usual occupation House wife

11. Industry or business

FATHER 12. Name Samuel Pfoutz

13. Birthplace Unknown

MOTHER 14. Maiden name Elizebeth Slouthorn

15. Birthplace unknown

16. Informant Mrs Marshell Senseney

Address R.F.D. Union Bridge, Md.

17. Beaver Dam (Burial, cremation, or removal. Which?) Date thereof Oct 6-3-9 (month) (day) (year)

Cemetery or crematory Beaver Dam

Location Union Bridge, Md.

18. Funeral director Raymond K. Wright

Address Union Bridge, Md.

19. Oct 6 – 1939 (Date rec'd by registrar) Margaret R. Englar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-3- 1939, at 5 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-3-1939, to 10-3-1939, and that I last saw h-x alive on 10-3-1939.

Immediate cause of death	DURATION
Acute Cardiac Dilitation	
Due to Chronic Myocarditis	
Due to Senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. N. Legg M D
M. D. or other

Address Union Bridge Date signed 10-4-39

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NOV 3 1939
BUREAU V. S.

09926

STATE OF MARYLAND—CERTIFICATE OF DEATH

1. PLACE OF DEATH (93d)

County CARROLL Registration Dist. No. 74

Village or City SYKESVILLE No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME MRS AMELIA ELIZABETH RICHARDSON If U. S. Veteran, specify WAR

(a) Residence: No. SYKESVILLE, MD. St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
FEMALE	WHITE	WIDOWED

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of JOHN THOMAS RICHARDSON

6. DATE OF BIRTH (month, day, and year) JAN. 20, 1857

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	9	19	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Housework

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. own home

10. Date deceased last worked at this occupation (month and year) Sep. 1939

11. Total time (years) spent in this occupation 73

12. BIRTHPLACE (city or town) DANIEL (State or country) MARYLAND

FATHER

13. NAME JOSEPH HILL GILLIS

14. BIRTHPLACE (city or town) DANIEL (State or country) MARYLAND

MOTHER

15. MAIDEN NAME AMELIE PICKETT

16. BIRTHPLACE (city or town) DANIEL near WINFIELD (State or country) MARYLAND

17. INFORMANT MRS JAMES GAITHER. (Address) SYKESVILLE, MD.

18. BURIAL, CREMATION, OR REMOVAL Place Bethel Cemetery Date Oct 10, 1939

19. UNDERTAKER C. H. Weer (Address) Sykesville Md.

20. FILED Oct 11, 1939 C. Harry Weer Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH October (Month) 9 (Day), 1939 (Year)

22. I HEREBY CERTIFY, That I attended deceased from SEPTBR 30, 1939, to October 9, 1939

I last saw her alive on October 9, 1939; death is said to have occurred on the date stated above, at 12 45 p.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
ARTERIOSCLEROSIS	1919
MYOCARDIAL HEART DISEASE	

Other Contributory Causes of Importance:

HYPOSTATIC PNEUMONIA, bronchial in type. Duration: eleven days.	1 week ago

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Jacob R. Jensen M. D.

(Address) Sykesville, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

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Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (46-E) ✓ Reg. Dist. No. 52

CERTIFICATE OF DEATH

09927

1. PLACE OF DEATH:
(a) County Carroll
(b) City or town New Windsor (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town New Windsor (If outside city or town limits, write RURAL and give town)
(d) Street No. Manse (If rural give location)
(e) If foreign born, how long in U. S. A.? ____ years

3 (a) **FULL NAME** Charles H. Bellman

3 (b) If veteran, name war No.
3 (c) Social Security No. no

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Nan Bellman

6. (c) If alive, give age no years

7. Birth date of deceased (mo., day, yr.) June 20 1860

8. **AGE:** Years 79 | Months 4 | Days 10 | If less than one day ____ hr. ____ min.

9. Birthplace Carroll Co Md (Town, county, and state)

10. Usual occupation Farm Supervisor

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace "

MOTHER
14. Maiden Name Not Known
15. Birthplace "

16 (a) Informant Mrs Walter Bankert
(b) Address New Windsor Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 8-39 (month) (day) (year)
(c) Cemetery or crematory Presbyterian Cemetery
Location New Windsor Md

18 (a) Funeral director J. D. Kappler & Son
(b) Address New Windsor Md

19 (a) Oct 9 1939 (Date rec'd by registrar) (b) ____ Registrar

MEDICAL CERTIFICATION

20. Date of death Oct 5 1939, at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1939, to Oct 5 1939, and that I last saw him alive on Oct 5 1939.

Immediate cause of death	Duration
Cardiac Dilatation	1 hr
Arterio Sclerosis	10 yr
Due to Carcinoma Liver	1 yr
Diabetes	9 yr
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. **Signature** Jas. I. Norris M D (M. D. or other)
Address New Windsor Md Date signed 10/6/39

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09928

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville, Md -
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Springfield State Hospital -

Stay in hospital or inst. (yrs., or mos., or days): 1 mo - 5 days

Stay in this community (yrs., or mos., or days): Life -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 820 Woodington Road -
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Joseph Shaffer -

3. (b) Social Security Number

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Unknown -

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): May 13, 1873.

8. AGE: Years 66 | Months 5 | Days 13 | If less than one day ____ hrs. ____ min.

9. Birthplace: Carroll County, Md
(Town, county, and state)

10. Usual occupation: Stone Mason -

11. Industry or business

FATHER
12. Name: Martin Shaffer
13. Birthplace: Carroll County

MOTHER
14. Maiden name: Catherine McAbee
15. Birthplace: Unknown

16. Informant: Hospital Records

Address: Sykesville, Md -

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof: Oct. 28 - 1939
(month) (day) (year)

Cemetery or ~~crematory~~: Woodlawn Cem.

Location: Balto. Co.

18. Funeral director: Geo. W. Little

Address: 2700 Edmondson Av.

19. Oct. 26 1939 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 26 1939, at 5 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h__ alive on ____ 19__.

Immediate cause of death	DURATION
Pneumonia (Aspiration)	10/24/39
Due to Tube feeding -	
Due to Arterio-Sclerotic psychosis	5 yrs -
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy: No -

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work? ____

23. SIGNATURE: Jas. T. Marsh Deputy Medical Examiner
M. D. or other

Address: New Windsor Md Date signed 10/26/39

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NOV 3 1939
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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09930

Reg. Dist. No. 83

1. PLACE OF DEATH:
County Carroll.
City or town Rural near Woodbine, Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 7 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll.
City or town Rural near Woodbine Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. R. D. Woodbine, Md.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Arthur Shipley

3. (b) Social Security Number No.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Elizabeth Shipley
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 14 1877

8. AGE:

Years	Months	Days	If less than one day
62	8	15	hrs. min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)
10. Usual occupation Laborer
11. Industry or business
FATHER 12. Name John W. Shipley
13. Birthplace Maryland
MOTHER 14. Maiden name Eliza Shipley
15. Birthplace Maryland
16. Informant Mr. Robert A. Shipley.
Address R. D. Sykesville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 31, 1939 (month) (day) (year)
Cemetery ~~or crematory~~ Brandenburg M. P.
Location Bennett, Carroll Co. Md.
18. Funeral director C. M. Walter
Address Winfield, Md
19. Oct 31 19 39 (Date rec'd by registrar) Edna M. Hewitt Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 29th 1939, at 5 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 20th 1939, to Oct 29th 1939, and that I last saw him alive on Oct 29th 1939.

Immediate cause of death Acute Myocarditis — DURATION 10 days
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE L. C. Shipley M. D. or other
Address New Windsor Date signed 10/29/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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STATE OF MARYLAND—CERTIFICATE OF DEATH

09929

1. PLACE OF DEATH

County CHARROLL Registration Dist. No. 74

Village or City SYKESVILLE, No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S. if of foraign birth? yrs. mos. ds.

2. FULL NAME (STILL BORN INFANT) SHIPLEY If U. S. Veteran, specify WAR

(a) Residence: No. St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	white	

5a. If married, widowed, or divorcad
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, and year) October 1, 1939

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Data deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) SYKESVILLE,
(State or country) MD

FATHER

13. NAME John Leslie Shipley

14. BIRTHPLACE (city or town) Near Winfield
(State or country) Woodbine P.O

MOTHER

15. MAIDEN NAME Marie Ernest Bittner

16. BIRTHPLACE (city or town) Baltimore
(State or country) Md -

17. INFORMANT Mrs John L Shipley
(Address) Sykesville, Md.

18. BURIAL, CREMATION, OR REMOVAL
Place Bethel Cem. Carroll Co. Md Date Oct. 7, 1939

19. UNDERTAKER A H Steer
(Address) Sykesville Md.

20. FILED Oct 1, 1939 A Harry Steer
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH October 1, 1939
(Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...

I last saw h... alive on ..., 19...; death is said to have occurred on the date stated above, at ...m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
Born dead	
Intrauterine asphyxia	
Other Contributary Causes of Importance:	

Name of operation ... Date of ...

What test confirmed diagnosis? ... Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ..., 19...

Where did injury occur? ...
(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury ...

Nature of Injury ...

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify ...

(Signed) Jacob P. Jensen M. D.

(Address) Sykesville Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none.**

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

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Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131)

CERTIFICATE OF DEATH

09931

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll Co.

City or town: Union Bridge, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: County:

City or town: Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Jethro Gorley Simmons

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Ida Simmons

6(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.):

8. AGE:

Years	Months	Days	If less than one day
70	7	12	____ hrs. ____ min.

9. Birthplace: Morefield W. Va
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER
12. Name: Sanford Simmons
13. Birthplace: Morefield W. Va.

MOTHER
14. Maiden name: Unkown
15. Birthplace:

16. Informant: Ida, Simmons
Address: Union Bridge, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 26, 39 (month) (day) (year)

Cemetery or crematory: Newhouse cemetary

Location: Rig W? Va

18. Funeral director: Raymond K. Wright

Address: Union Bridge, Md.

19. Oct 23, 1939 (Date rec'd by registrar) Margaret R. Englar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 23 1939, at 8 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 6, 1939, to Oct. 22 1939, and that I last saw him alive on Oct. 22 1939.

Immediate cause of death	DURATION
Bronchopneumonia	
Due to	
Due to	
Other conditions: Chronic Myocarditis, Chronic Nephritis	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: R. S. McVaugh M. D. or other

Address: Taneytown, Md. Date signed: Oct. 23, 39

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

09932

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days): 2 months 2 days

Stay in this community (yrs., or mos., or days): (Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Towson Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 416 Pennsylvania Ave.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: James Benjamin Smith

3. (b) Social Security Number: ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

8 (b) Name of husband or wife: ---

6(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): Sept. 6, 1890

8. AGE:

Years	Months	Days	If less than one day
49	1	0	---hrs. ---min.

9. Birthplace: Towson, Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: ---

FATHER
12. Name: John Smith
13. Birthplace: Harford County, Maryland

MOTHER
14. Maiden name: Emma Preston
15. Birthplace: Harford County, Maryland

16. Informant: Dr. Reuben Hoffman,
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 10 1939 (month) (day) (year)

Cemetery or crematory: Pleasant Rest

Location: Towson

18. Funeral director: George Holland

Address: 1600 Druid Hill Ave

19. 10/6/39 (Date rec'd by registrar) 19 Albert R. Swanbeam Deputy Registrar

MEDICAL CERTIFICATION 5:05 P.M.

20. DATE OF DEATH: Oct. 6, 1939 19---, at ---M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 4, 1939 19---, to Oct. 6, 1939 19---,
and that I last saw him alive on Oct. 6, 1939 19---

Immediate cause of death: Pulmonary Tuberculosis — DURATION: June 1939

Due to: ---

Due to: ---

Other conditions: ---

(Include pregnancy within 3 months of death)

Major findings:

Of operations: --

Of autopsy: No Autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?): ---

Means of injury Injured at work?

23. SIGNATURE: Reuben Hoffman M.D.
M. D. or other

Address: Henryton, Maryland Date signed: 10/6/39

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09933

CERTIFICATE OF DEATH

Reg. Dist. No. 81

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll County

City or town: Union Bridge, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: County:

City or town: Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Bernard Lee Virts

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Carrie Lee Virts

6(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): 1895 Oct, 23

8. AGE: Years	Months	Days	If less than one day
44		7	hrs. min.

9. Birthplace: Frederick City, Md.
(Town, county, and state)

10. Usual occupation: Labor

11. Industry or business: Western Maryland R.R.

FATHER 12. Name: Benjman Virts

13. Birthplace: Unknown

MOTHER 14. Maiden name: Unknown

15. Birthplace:

16. Informant: Mrs. Carrie Lee Virts
Address: Union Bridge, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 1.39 (month) (day) (year)

Cemetery or crematory: Beaver Dam

Location: Union Bridge, Md.

18. Funeral director: Raymond K. Wright
Address: Union Bridge, Md.

19. Oct-31-39 (Date rec'd by registrar) P. Eichman Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10-29-1939, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-29-1939, to 10-30-1939, and that I last saw h[illegible] alive on 10-29-1939.

Immediate cause of death	DURATION
Cardiac Dilatation	
Due to (probably) Lues	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: D. H. Legg M.D.
M. D. or other

Address: Union Bridge Date signed: 10-30-39

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MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

(120)

09934

CERTIFICATE OF DEATH

Reg. Dist. No. 71

1. PLACE OF DEATH:
County Carroll
City or town Uniontown
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State County
City or town Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mrs Julia Washinger

3. (b) Social Security Number

4. Sex F
5. Color or race W
6. (a) Single, married, widowed, or divorced married
6 (b) Name of husband or wife John B. Washinger
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 18, 1858

8. AGE: Years 81 Months 5 Days 3 If less than one day hrs. min.

9. Birthplace Md
(Town, county, and state)
10. Usual occupation Housework
11. Industry or business
FATHER 12. Name Jacob R. Dingle
13. Birthplace Md
MOTHER 14. Maiden name Unknown
15. Birthplace Unknown
16. Informant Charles Waltz
Address Uniontown, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 25, 1939 (month) (day) (year)
Cemetery or crematory Ch of God
Location Uniontown, Md.
18. Funeral director C. A. Fussbon
Address Taneytown, Md.
19. Oct. 25 1939 (Date rec'd by registrar) Margaret R. Englar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 21 1939, at 3 p M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1939, to Oct 21 1939, and that I last saw h ex alive on Oct 21 1939.
Immediate cause of death Intestinal Ulcers
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. N. Legg M.D.
M. D. or other
Address Union Bridge Date signed 10-22-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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NOV 3 1939
AU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09935

CERTIFICATE OF DEATH

Reg. Dist. No. 81 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Union Bridge
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: R.R. Street

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Union Bridge Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Railroad Ave.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Margaret Jane Wetzel

3. (b) Social Security Number

4. Sex Female | 5. Color or race White | 6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife John E Wetzel

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Sept 15 1880

8. AGE: Years 59 | Months 0 | Days 18 | If less than one day ___ hrs. ___ min.

9. Birthplace Carroll Co Md
(Town, county, and state)

10. Usual occupation Housekeeper

11. Industry or business At home

FATHER 12. Name Joseph Fowler

FATHER 13. Birthplace Carroll Co. Md

MOTHER 14. Maiden name Scheue

MOTHER 15. Birthplace not known

16. Informant John E Wetzel

Address Union Bridge Md

17. (Burial, cremation, or removal. Which?) Burial Date thereof (month) oct (day) 6 (year) 39

Cemetery or crematory Pipe Creek Cem.

Location Near Uniontown, Md

18. Funeral director D D Hamilton & Sons

Address Union Bridge Md

19. (Date rec'd by registrar) Oct. 6, 1939 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 3 1939, at 5 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 30 1939, to Oct 3 1939, and that I last saw h ex-alive on Oct 3 1939.

Immediate cause of death Lobar Pneumonia — DURATION 4 days

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. N. Legg M. D.
M. D. or other

Address Union Bridge Date signed 10-4-39

RECEIVED
NOV 8 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23

09936

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maryland Tuberculosis Sanatorium Colored Branch

Stay in hospital or inst. (yrs., or mos., or days): 1 year 6 days

Stay in this community (yrs., or mos., or days): (Above)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 521 N. Gilmore St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Bertha Williams

3. (b) Social Security Number: ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife: Charles Williams

6(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): Jan. 19, 1904

8. AGE:

Years	Months	Days	If less than one day
35	7	16	---- hrs. ---- min.

9. Birthplace: Mt. Airy, Maryland
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: ---

FATHER
12. Name: Basil Dorsey
13. Birthplace: Lisbon, Maryland

MOTHER
14. Maiden name: Letitia Dorsey
15. Birthplace: Lisbon, Maryland

16. Informant: Dr. Reuben Hoffman

Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/7/39 (month) (day) (year)

Cemetery or crematory: Fairview Cemetery

Location: Cover Corner, Carroll Co. Md.

18. Funeral director: C. M. Walty

Address: Winfield Md.

19. 10/5/39 (Date rec'd by registrar) Albert R. Swankhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 5, 1939 19---, at 2:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 29, 1938 to Oct. 5, 1939, and that I last saw her alive on Oct. 5, 1939.

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Jan. 1938
Due to: --	
Due to: ---	
Other conditions: ---	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: --

Of autopsy: No Autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of: --

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): --

Means of injury: -- Injured at work? --

23. SIGNATURE: Reuben Hoffman, M. D.
M. D. or other

Address: Henryton, Maryland Date signed: 10/5/39

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
OCT 12 1939
BUREAU V. S.